Outline of Medicare Supplement Coverage

Benefit Plans A, C, F, G, L, N for 2025

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Outline of Medicare Supplement Coverage

Benefit Plans A, C, F, G, L, N for 2025

These charts show the benefits included in each of the standard Medicare Supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Plans Available to All Applicants					
A	**B**	**D**	**G**	**K**	**L**
Basic Benefits including 100% Part B Coinsurance	Basic Benefits including 100% Part B Coinsurance	Basic Benefits including 100% Part B Coinsurance	Basic Benefits including 100% Part B Coinsurance	Hospitalization and Preventive Care paid at 100%; other Basic Benefits paid at 50%	Hospitalization and Preventive Care paid at 100%; other Basic Benefits paid at 75%
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible
			Part B Excess (100%)		
		Foreign Travel Emergency	Foreign Travel Emergency		
				Out-of-pocket limit $7,220; paid at 100% after limit is reached.	Out-of-pocket limit $3,610; paid at 100% after limit is reached.

*Plan F has an option called a High Deductible Plan F. This high deductible plan pays the same benefits as Plan F after the subscriber has paid a calendar year $2,870 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses exceed $2,870. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Basic Benefits

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require the subscriber to pay a portion of Part B coinsurance or copayments.

Blood: First three pints of blood each year.

Hospice: Part A coinsurance.

			Medicare First Eligible Before 2020 Only		
	M	**N**	**C**	**F**	**F***
	Basic Benefits including 100% Part B Coinsurance	Basic Benefits; including 100% Part B Coinsurance, except up to $20 Copayment per office visit, and up to $50 Copayment per emergency room visit	Basic Benefits including 100% Part B Coinsurance	Basic Benefits including 100% Part B Coinsurance	
	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	
	50% Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
			Part B Deductible	Part B Deductible	
				Part B Excess (100%)	
	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	

Starting January 1, 2020, Medigap plans sold to new people with Medicare won't be allowed to cover the Part B deductible. Because of this, Plans C and F will no longer be available to people new to Medicare starting on January 1, 2020. If you already have either of these 2 plans (or the high deductible version of Plan F) or are covered by one of these plans before January 1, 2020, you'll be able to keep your plan. If you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy one of these plans.

Key ☐ Plans offered by Blue Cross Blue Shield of North Dakota

Premium Information

We, Blue Cross Blue Shield of North Dakota, can only raise your premium if we raise the premium for all benefit plans like yours in this state. In addition to these general increases, your premium will increase each year to correspond with your age.

Disclosures

Use this outline to compare benefits and premiums among benefit plans.

Read Your Benefit Plan Very Carefully

This is only an outline describing your benefit plan's most important features. The benefit plan is your insurance contract. You must read the benefit plan itself to understand all the rights and duties of both you and your insurance company.

Right to Return Benefit Plan

If you find that you are not satisfied with your benefit plan, you may return it to 4510 13th Avenue South, Fargo, ND 58121. If you send the benefit plan back to us within 30 days after you receive it, we will treat the benefit plan as if it had never been issued and return all of your premium.

Benefit Plan Replacement

If you are replacing another health insurance benefit plan, do NOT cancel it until you have actually received your new benefit plan and are sure you want to keep it.

Notice

This benefit plan may not fully cover all of your medical costs.

Neither Blue Cross Blue Shield of North Dakota nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare and You" for more details.

Complete Answers are Very Important

When you fill out the application for the new benefit plan, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your benefit plan and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

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Plan A Rates

Plan A Rate Structure – Effective January 1, 2025

	Female		Male	
Age	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
65	$113.00	$135.20	$113.70	$136.40
66	$113.80	$136.70	$115.60	$138.40
67	$115.70	$138.70	116.60	140.40
68	$120.90	$144.60	124.70	149.70
69	$125.50	$151.00	132.00	159.00
70	$130.90	$156.40	$140.10	$168.10
71	$135.80	$162.70	$147.20	$177.00
72	$140.60	$168.80	$155.30	$186.20
73	$145.10	$174.30	$161.80	$194.20
74	$149.80	$180.20	$168.10	$201.80
75	$154.80	$185.70	$174.50	$209.30
76	$159.20	$191.00	$181.20	$217.00
77	$164.20	$196.80	$187.50	$224.40
78	$167.40	$200.90	$192.50	$230.50
79	$170.90	$204.60	$197.30	$236.90
80	$174.30	$208.90	$201.90	$242.80
81	$177.10	$212.70	$207.30	$248.70
82	$180.90	$217.00	$212.00	$254.60
83	$183.70	$220.20	$216.40	$260.00
84	$186.20	$224.00	$220.40	$264.80
85	$189.40	$227.40	$224.80	$269.90
86	$192.40	$230.50	$229.10	$275.30
87	$195.00	$233.80	$233.20	$279.90
88	$197.30	$236.90	$235.80	$282.90
89	$199.50	$239.70	$238.00	$286.00
90	$201.80	$242.30	$240.30	$288.40
91	$203.90	$245.30	$242.80	$291.50
92	$206.30	$247.40	$245.40	$294.30
93	$208.40	$249.90	$247.20	$296.60
94	$210.70	$252.70	$249.50	$299.50
95	$212.40	$255.40	$251.90	$302.20
96	$214.90	$257.80	$253.80	$304.70
97	$217.00	$260.60	$256.10	$307.40
98	$219.50	$263.00	$258.20	$310.20
99	$221.30	$265.50	$260.50	$312.60
100+	$221.30	$265.50	$260.50	$312.60

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Plan C Rates

Plan C Rate Structure – Effective January 1, 2025

	Female		Male	
Age	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
65	$209.60	$251.50	$212.00	$254.20
66	$212.30	$255.00	$214.80	$257.80
67	$215.00	$258.20	$217.70	$260.90
68	$224.30	$269.30	$232.00	$278.50
69	$233.50	$280.70	$246.10	$295.50
70	$243.00	$291.60	$260.60	$312.70
71	$252.20	$303.10	$274.90	$329.80
72	$261.50	$313.90	$289.20	$346.70
73	$270.10	$324.70	$300.80	$361.60
74	$278.80	$334.80	$313.10	$375.90
75	$287.80	$345.50	$325.10	$389.70
76	$296.50	$355.70	$336.90	$404.40
77	$305.00	$365.90	$348.90	$418.70
78	$311.60	$373.90	$357.80	$429.60
79	$317.40	$381.00	$367.20	$440.90
80	$324.30	$389.10	$376.40	$451.40
81	$330.50	$396.30	$385.40	$462.50
82	$336.70	$404.00	$394.90	$473.70
83	$342.20	$410.30	$402.80	$483.30
84	$347.00	$416.50	$410.50	$492.80
85	$352.70	$422.80	$418.80	$502.10
86	$357.70	$429.40	$426.40	$511.70
87	$362.90	$435.60	$434.30	$521.30
88	$367.20	$440.90	$438.70	$526.70
89	$371.40	$446.00	$443.50	$531.90
90	$376.10	$450.70	$447.70	$536.90
91	$379.90	$455.80	$451.90	$542.30
92	$384.10	$461.00	$456.30	$547.50
93	$388.00	$466.00	$460.10	$552.40
94	$392.20	$470.80	$464.50	$557.10
95	$396.20	$475.40	$468.60	$562.30
96	$400.40	$480.20	$472.60	$567.50
97	$404.40	$484.80	$476.90	$572.20
98	$408.20	$489.70	$480.70	$577.10
99	$412.00	$494.80	$484.80	$582.30
100+	$412.00	$494.80	$484.80	$582.30

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Plan F Rates

Plan F Rate Structure – Effective January 1, 2025

	Female		Male	
Age	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
65	$227.50	$272.90	$230.20	$276.10
66	$230.50	$276.70	$233.00	$279.70
67	$233.50	$280.70	$236.40	$283.70
68	$243.80	$292.20	$252.00	$302.60
69	$253.80	$304.70	$267.40	$320.80
70	$264.30	$316.70	$282.80	$339.70
71	$273.90	$328.30	$298.30	$357.80
72	$283.80	$341.00	$313.90	$376.40
73	$294.00	$352.40	$326.80	$392.20
74	$303.10	$363.50	$339.80	$407.50
75	$312.50	$374.70	$352.90	$423.00
76	$322.00	$386.20	$365.50	$438.70
77	$330.90	$397.20	$378.70	$454.10
78	$337.90	$405.40	$388.50	$466.40
79	$345.10	$413.90	$398.60	$478.00
80	$351.90	$422.20	$408.30	$490.20
81	$358.50	$430.30	$418.70	$502.00
82	$365.40	$438.40	$428.50	$514.30
83	$371.00	$445.30	$437.20	$524.50
84	$376.70	$452.30	$446.00	$535.10
85	$382.70	$459.20	$454.60	$545.20
86	$388.00	$466.30	$463.20	$555.60
87	$393.90	$472.70	$471.70	$565.80
88	$398.80	$478.00	$476.40	$572.00
89	$403.20	$484.00	$480.90	$577.40
90	$407.70	$489.50	$485.90	$583.10
91	$412.60	$495.00	$490.30	$588.50
92	$417.00	$500.30	$495.50	$594.00
93	$421.30	$505.70	$499.40	$599.50
94	$425.40	$510.90	$504.30	$604.70
95	$430.20	$516.10	$508.60	$610.60
96	$434.20	$521.00	$512.90	$615.60
97	$438.50	$526.40	$517.50	$620.80
98	$443.00	$531.60	$521.70	$626.00
99	$447.10	$536.80	$526.40	$631.60
100+	$447.10	$536.80	$526.40	$631.60
Disabled	$403.20	$484.00	$403.20	$484.00

High Deductible Plan F Rates

High Deductible Plan F Rate Structure – Effective January 1, 2025

	Female		Male	
Age	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
65	$59.10	$71.40	$60.00	$72.20
66	$60.40	$72.40	$61.00	$73.30
67	$61.10	$73.40	$61.50	$74.10
68	$63.70	$76.50	$65.90	$79.10
69	$66.50	$79.70	$69.70	$84.10
70	$69.00	$82.80	$73.90	$88.50
71	$71.70	$85.70	$77.80	$93.50
72	$74.30	$89.20	$82.00	$98.60
73	$76.70	$92.00	$85.30	$102.60
74	$79.10	$95.10	$89.10	$106.50
75	$81.60	$98.40	$92.10	$110.60
76	$84.20	$100.80	$95.30	$114.50
77	$86.50	$103.70	$98.90	$118.60
78	$88.20	$106.10	$101.40	$121.90
79	$90.20	$108.20	$103.80	$125.10
80	$92.00	$110.50	$106.60	$128.00
81	$93.50	$112.40	$109.30	$131.40
82	$95.30	$114.50	$111.80	$134.70
83	$96.90	$116.40	$114.20	$137.00
84	$98.70	$118.40	$116.40	$139.80
85	$100.10	$119.90	$118.70	$142.50
86	$101.40	$121.90	$120.90	$145.30
87	$103.10	$123.70	$123.50	$148.10
88	$103.80	$125.10	$124.40	$149.40
89	$105.60	$126.40	$125.60	$150.70
90	$106.50	$127.80	$126.80	$152.40
91	$108.00	$129.30	$128.00	$153.70
92	$109.00	$130.70	$129.50	$155.30
93	$110.40	$132.10	$130.50	$157.00
94	$111.00	$133.50	$131.80	$158.00
95	$112.40	$134.90	$132.80	$159.60
96	$113.80	$136.00	$134.20	$161.00
97	$114.50	$137.50	$135.20	$162.10
98	$116.00	$138.80	$136.10	$163.80
99	$116.70	$140.10	$137.50	$165.00
100+	$116.70	$140.10	$137.50	$165.00

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Plan G Rates

Plan G Rate Structure – Effective January 1, 2025

	Female		Male	
Age	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
65	$177.10	$212.70	$179.50	$215.40
66	$179.80	$215.90	$181.70	$218.20
67	$182.10	$219.00	$184.40	$221.30
68	$190.30	$228.00	$196.80	$236.30
69	$197.90	$237.80	$208.40	$250.00
70	$206.20	$246.90	$220.50	$264.80
71	$213.50	$256.10	$232.60	$279.10
72	$221.40	$265.80	$245.00	$293.70
73	$229.10	$274.70	$255.00	$305.80
74	$236.40	$283.40	$265.00	$318.00
75	$243.60	$292.30	$275.20	$330.10
76	$251.30	$301.20	$285.20	$342.30
77	$258.20	$309.80	$295.40	$354.40
78	$263.60	$316.30	$303.20	$363.90
79	$269.10	$322.70	$311.10	$373.20
80	$274.10	$329.10	$318.50	$382.60
81	$279.50	$335.60	$326.50	$391.70
82	$285.00	$342.10	$334.30	$401.10
83	$289.50	$347.50	$341.00	$409.10
84	$294.00	$352.70	$347.70	$417.40
85	$298.40	$358.30	$354.50	$425.20
86	$302.60	$363.70	$361.40	$433.30
87	$307.30	$368.70	$367.90	$441.50
88	$311.10	$373.20	$371.50	$446.30
89	$314.60	$377.50	$375.10	$450.40
90	$318.00	$381.80	$379.10	$454.80
91	$321.90	$386.10	$382.70	$459.10
92	$325.20	$390.10	$386.40	$463.60
93	$328.80	$394.50	$389.60	$467.80
94	$331.90	$398.40	$393.40	$471.50
95	$335.40	$402.40	$396.70	$476.20
96	$338.70	$406.50	$400.20	$480.10
97	$342.20	$410.50	$403.80	$484.20
98	$345.70	$414.40	$407.00	$488.20
99	$349.00	$418.70	$410.50	$492.70
100+	$349.00	$418.70	$410.50	$492.70

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Plan L Rates

Plan L Rate Structure – Effective January 1, 2025

	Female		Male	
Age	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
65	$147.60	$177.10	$149.50	$179.50
66	$149.80	$180.20	$151.50	$181.70
67	$152.00	$182.10	$153.40	$184.40
68	$158.90	$190.30	$163.60	$196.70
69	$164.70	$198.10	$173.60	$208.70
70	$171.70	$206.00	$183.90	$220.40
71	$178.20	$213.50	$194.00	$232.60
72	$184.70	$221.60	$203.90	$244.40
73	$190.60	$229.00	$212.30	$255.00
74	$197.10	$236.40	$221.10	$265.00
75	$203.20	$243.40	$229.30	$275.30
76	$209.10	$251.00	$237.80	$285.50
77	$215.00	$258.20	$246.00	$295.20
78	$219.70	$263.60	$252.20	$303.20
79	$224.20	$269.00	$258.90	$310.60
80	$228.60	$274.30	$265.50	$318.90
81	$233.00	$279.40	$271.60	$326.00
82	$237.40	$285.00	$278.50	$334.40
83	$241.00	$289.50	$284.20	$341.00
84	$245.30	$294.20	$289.80	$347.50
85	$248.80	$298.40	$295.50	$354.50
86	$252.20	$303.20	$300.80	$361.60
87	$256.10	$307.40	$306.60	$367.60
88	$259.10	$310.60	$309.50	$371.50
89	$262.20	$314.60	$312.70	$375.20
90	$265.30	$318.00	$315.70	$379.10
91	$268.10	$321.90	$319.00	$382.70
92	$270.90	$325.20	$322.10	$386.30
93	$273.90	$328.30	$324.90	$389.70
94	$276.70	$332.10	$327.90	$393.00
95	$279.20	$335.20	$330.50	$396.40
96	$282.30	$338.90	$333.50	$400.40
97	$285.30	$342.30	$336.50	$403.80
98	$287.80	$345.80	$339.10	$407.20
99	$290.90	$349.00	$342.30	$410.40
100+	$290.90	$349.00	$342.30	$410.40

ND

Plan N Rates

Plan N Rate Structure – Effective January 1, 2025

	Female		Male	
Age	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
65	$159.20	$190.70	$160.80	$193.10
66	$161.60	$193.80	$163.40	$195.50
67	$163.60	$196.70	$165.00	$198.60
68	$170.90	$204.60	$176.40	$211.70
69	$177.60	$213.20	$186.70	$224.40
70	$184.80	$221.60	$198.10	$237.80
71	$192.10	$230.20	$208.90	$250.60
72	$198.60	$238.40	$219.70	$263.40
73	$205.80	$246.60	$229.00	$274.30
74	$212.00	$254.60	$237.90	$285.50
75	$218.80	$262.50	$247.00	$296.10
76	$224.90	$270.00	$255.80	$307.40
77	$231.90	$278.20	$265.00	$317.70
78	$236.90	$283.80	$271.60	$326.00
79	$241.40	$289.80	$278.80	$334.80
80	$246.10	$295.50	$286.10	$343.30
81	$251.30	$300.90	$293.50	$351.40
82	$255.80	$306.90	$299.90	$359.70
83	$260.00	$311.80	$306.20	$367.20
84	$263.60	$316.70	$312.10	$374.20
85	$267.90	$321.30	$318.00	$382.10
86	$271.50	$326.00	$324.30	$389.10
87	$276.00	$330.90	$330.40	$396.20
88	$279.10	$334.80	$333.60	$400.50
89	$282.30	$338.20	$336.90	$404.40
90	$285.60	$342.80	$340.00	$408.20
91	$288.60	$346.20	$343.50	$412.00
92	$291.70	$350.00	$346.60	$416.00
93	$295.00	$353.70	$349.50	$419.80
94	$298.10	$357.50	$353.00	$423.30
95	$300.80	$361.60	$355.80	$427.40
96	$304.00	$365.10	$359.00	$431.00
97	$307.10	$368.40	$362.10	$434.70
98	$310.20	$371.80	$365.40	$438.40
99	$313.10	$376.10	$368.40	$442.00
100+	$313.10	$376.10	$368.40	$442.00

ND | Plan A

Medicare (Part A) Hospital Services Per Calendar Year			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Hospitalization*: Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,676	$0	$1,676 (Part A deductible)
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after			
While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used			
Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care*: You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	$0	Up to $209.50 a day
101st day and after	$0	$0	All costs
Blood			
First three pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care: You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	$0

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

****Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

***Once you have been billed $257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

Medicare (Part B) Medical Services Per Calendar Year			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Medical Expenses: In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, and durable medical equipment			
First $257 of Medicare-approved amounts***	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
Blood			
First three pints	$0	All costs	$0
Next $257 of Medicare-approved amounts***	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services: Tests for diagnostic services.			
	100%	$0	$0

Parts A and B			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Home Health Care: Medicare-approved services.			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $257 of Medicare-approved amounts***	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

ND | Plan G

Medicare (Part A) Hospital Services Per Calendar Year			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Hospitalization*: Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after			
While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used			
Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care*: You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First three pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care: You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	$0

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

****Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

***Once you have been billed $257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

Medicare (Part B) Medical Services Per Calendar Year			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Medical Expenses: In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, and durable medical equipment.			
First $257 of Medicare-approved amounts***	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First three pints	$0	All costs	$0
Next $257 of Medicare-approved amounts***	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services: Tests for diagnostic services.			
	100%	$0	$0
Parts A and B			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Home Health Care: Medicare-approved services.			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $257 of Medicare-approved amounts***	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Other Benefits Not Covered by Medicare			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Foreign Travel: Not covered by Medicare – Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

ND | Plan L

Medicare (Part A) Hospital Services Per Calendar Year			
Services	**Medicare Pays**	**Plan Pays**	**You Pay***
Hospitalization:** Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,676	$1,257 (75% of Part A deductible)	$419 (25% of Part A deductible) ♦
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after			
While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used			
Additional 365 days	$0	100% of Medicare eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care:** You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $157.12 a day	Up to $52.38 a day ♦
101st day and after	$0	$0	All costs
Blood			
First three pints	$0	75%	25% ♦
Additional amounts	100%	$0	$0
Hospice Care: You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	75% of Medicare copayment / coinsurance	25% of Medicare copayment / coinsurance ♦

Medicare (Part B) Medical Services Per Calendar Year			
Services	**Medicare Pays**	**Plan Pays**	**You Pay***
Medical Expenses: In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, and durable medical equipment.			
First $257 of Medicare-approved amounts****	$0	$0	$257 (Part B deductible) ♦
Preventive benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $3,610)*

Medicare (Part B) Medical Services Per Calendar Year			
Services	**Medicare Pays**	**Plan Pays**	**You Pay***
Blood			
First three pints	$0	75%	25% ♦
Next $257 of Medicare-approved amounts****	$0	$0	$257 (Part B deductible) ♦
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5% ♦
Clinical Laboratory Services: Tests for diagnostic services.			
	100%	$0	$0

Parts A and B			
Services	**Medicare Pays**	**Plan Pays**	**You Pay***
Home Health Care: Medicare-approved services.			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $257 of Medicare-approved amounts*****	$0	$0	$257 (Part B deductible) ♦
Remainder of Medicare-approved amounts	80%	15%	5% ♦

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $3,610 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

***__Notice:__ When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

****Once you have been billed $257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

*****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

ND | Plan N

Medicare (Part A) Hospital Services Per Calendar Year			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Hospitalization*: Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after			
While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used			
Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care*: You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First three pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care: You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	$0

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

****Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

***Once you have been billed $257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

Medicare (Part B) Medical Services Per Calendar Year			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Medical Expenses: In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, and durable medical equipment.			
First $257 of Medicare-approved amounts***	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the subscriber is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the subscriber is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs
Blood			
First three pints	$0	All costs	$0
Next $257 of Medicare-approved amounts***	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services: Tests for diagnostic services.			
	100%	$0	$0

Parts A and B			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Home Health Care: Medicare-approved services.			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $257 of Medicare-approved amounts***	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits Not Covered by Medicare			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Foreign Travel: Not covered by Medicare – Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

ND | Plan C

Medicare (Part A) Hospital Services Per Calendar Year			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Hospitalization*: Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after			
While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used			
Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care*: You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First three pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care: You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	$0

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

****Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

***Once you have been billed $257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

Medicare (Part B) Medical Services Per Calendar Year			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Medical Expenses: In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, and durable medical equipment.			
First $257 of Medicare-approved amounts***	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs
Blood			
First three pints	$0	All costs	$0
Next $257 of Medicare-approved amounts***	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services: Tests for diagnostic services.			
	100%	$0	$0
Parts A and B			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Home Health Care: Medicare-approved services.			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $257 of Medicare-approved amounts***	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Other Benefits Not Covered by Medicare			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Foreign Travel: Not covered by Medicare – Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Starting January 1, 2020, Medigap plans sold to new people with Medicare won't be allowed to cover the Part B deductible. Because of this, Plans C and F will no longer be available to people new to Medicare starting on January 1, 2020. If you already have either of these 2 plans (or the high deductible version of Plan F) or are covered by one of these plans before January 1, 2020, you'll be able to keep your plan. If you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy one of these plans.

ND | Plan F

Medicare (Part A) Hospital Services Per Calendar Year			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Hospitalization*: Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after			
While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used			
Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care*: You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First three pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care: You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	$0

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

****Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

***Once you have been billed $257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

Medicare (Part B) Medical Services Per Calendar Year			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Medical Expenses: In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, and durable medical equipment.			
First $257 of Medicare-approved amounts***	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First three pints	$0	All costs	$0
Next $257 of Medicare-approved amounts***	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services: Tests for diagnostic services			
	100%	$0	$0
Parts A and B			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Home Health Care: Medicare-approved services.			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $257 of Medicare-approved amounts***	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Other Benefits Not Covered by Medicare			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Foreign Travel: Not covered by Medicare – Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Starting January 1, 2020, Medigap plans sold to new people with Medicare won't be allowed to cover the Part B deductible. Because of this, Plans C and F will no longer be available to people new to Medicare starting on January 1, 2020. If you already have either of these 2 plans (or the high deductible version of Plan F) or are covered by one of these plans before January 1, 2020, you'll be able to keep your plan. If you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy one of these plans.

ND High Deductible Plan F

Medicare (Part A) Hospital Services Per Calendar Year			
Services	**Medicare Pays**	**After You Pay $2,870 Deductible,**** Plan Pays**	**In addition to $2,870 Deductible,**** You Pay**
Hospitalization*: Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after			
While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used			
Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care*: You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First three pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care: You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

****Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

***Once you have been billed $257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

****This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $2,870 deductible. Benefits from the High Deductible Plan F will not begin until out-of-pocket expenses are $2,870. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

Medicare (Part B) Medical Services Per Calendar Year			
Services	**Medicare Pays**	**After You Pay $2,870 Deductible,**** **Plan Pays**	**In addition to $2,870 Deductible,**** **You Pay**
Medical Expenses: In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, and durable medical equipment.			
First $257 of Medicare-approved amounts***	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First three pints	$0	All costs	$0
Next $257 of Medicare-approved amounts***	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services: Tests for diagnostic services.			
	100%	$0	$0

Parts A and B			
Services	**Medicare Pays**	**After You Pay $2,870 Deductible,**** **Plan Pays**	**In addition to $2,870 Deductible,**** **You Pay**
Home Health Care: Medicare-approved services.			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $257 of Medicare-approved amounts***	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits Not Covered by Medicare			
Services	**Medicare Pays**	**After You Pay $2,870 Deductible,**** **Plan Pays**	**In addition to $2,870 Deductible,**** **You Pay**
Foreign Travel: Not covered by Medicare – Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

In accordance with federal regulations, Blue Cross Blue Shield of North Dakota is required to provide you the following disclosure:

Blue Cross Blue Shield of North Dakota complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender identity, sexual orientation or sex. Blue Cross Blue Shield of North Dakota does not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity, sexual orientation or sex.

Blue Cross Blue Shield of North Dakota:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call Member Services at 1-844-363-8457 (toll-free) or through the North Dakota Relay at 1-800-366-6888 or 711.

If you believe that Blue Cross Blue Shield of North Dakota has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, gender identity, sexual orientation or sex, you can file a grievance with:

Civil Rights Coordinator
4510 13th Ave S
Fargo, ND 58121
701-297-1638 or North Dakota Relay at 800-366-6888 or 711
701-282-1804 (fax)
CivilRightsCoordinator@bcbsnd.com (email) (Communication by unencrypted email presents a risk.)

You can file a grievance in person or by mail, fax, or email within 180 days of the date of the alleged discrimination. Grievance forms are available at http://www.bcbsnd.com/report or by calling 1-844-363-8457. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
800-368-1019 or 800-537-7697 (TDD)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-363-8457 (TTY: 1-800-366-6888 o 711).

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-363-8457 (TTY: 1-800-366-6888 oder 711).

中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-363-8457（TTY：1-800-366-6888 或 711）。

Oroomiffa (Oromo)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-844-363-8457 (TTY: 1-800-366-6888 ykn 711).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-844-363-8457 (TTY: 1-800-366-6888 hoặc 711).

Ikirundi (Bantu – Kirundi)

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu.
Woterefona 1-844-363-8457 (TTY: 1-800-366-6888 canke 711).

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-363-8457 (رقم هاتف الصم والبكم: 1-800-366-6888 أو711).

Kiswahili (Swahili)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo.
Piga simu 1-844-363-8457 (TTY: 1-800-366-6888 au 711).

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-844-363-8457 (телетайп: 1-800-366-6888 или 711).

日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-363-8457
（TTY: 1-800-366-6888 または 711）まで、お電話にてご連絡ください。

नेपाली (Nepali)

ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-844-363-8457 (टिटिवाइ: 1-800-366-6888 वा 711) ।

Français (French)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
Appelez le 1-844-363-8457 (ATS : 1-800-366-6888 ou 711).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-363-8457
(TTY: 1-800-366-6888 또는 711)번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-363-8457 (TTY: 1-800-366-6888 o 711).

Norsk (Norwegian)

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-844-363-8457 (TTY: 1-800-366-6888 eller 711).

Diné Bizaad (Navajo)

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-844-363-8457 (TTY: 1-800-366-6888 éí doodagó 711.)

Further facts on coverage, rates and enrollment are available from:

Fargo Office
4510 13th Ave. S.
Fargo, ND 58121
Telephone: (701) 277-2232

Bismarck Office
1415 Mapleton Ave.
Bismarck, ND 58503
Telephone: (701) 223-6348

Grand Forks Office
3570 S. 42nd St., Suite B
Grand Forks, ND 58201
Telephone: (701) 795-5340

Minot Office
1308 20th Ave. SW.
Minot, ND 58701
Telephone: (701) 858-5000

Jamestown Office
300 2nd Ave. NE., Suite 132
Jamestown, ND 58401
Telephone: (701) 251-3180

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1500 14th St. W., Suite 270
Williston, ND 58801
Telephone: (701) 572-4535

Call Toll-Free: (800) 280-BLUE (2583)

www.MedicareND.com

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